Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
101 PASEO DEL PRADO
EDINBURG TX 78539

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
#01

MFDR Tracking Number
M4-10-3312-01

MFDR Date Received
MARCH 22, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Doctors Hospital at Renaissance is kindly requesting that the above claim be reprocessed and paid correctly…..Per you representatives….the certification was not included and therefore no payment would be made on implants until received. The certification was mailed with the original claim and again with reconsideration."

Amount in Dispute: $3,434.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance/Division of Workers' Compensation Commission's Acts and Rules…The bill and documentation attached to the medical dispute have been re-reviewed as follows: Doctors Hospital at Renaissance submitted a blanket statement of certification with the implant invoices, however each invoice was not individually per TDI Rule 134.404(g)(1). This rule is for providers asking for separate reimbursement for implants. The provider must certify each invoice with the statement, 'I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge.' If the invoices do not contain this statement, then they do not get separate reimbursement. This verification statement of Rule 134.404(g)(1) was sent via email from one of the TDI medical dispute team. Doctors Hospital at Renaissance was paid per the Texas Workers' Compensation fee schedule by DRG 460 @143% of the Medicare allowance. Liberty Mutual believes that Doctors Hospital at Renaissance has been appropriately reimbursed for services rendered to…for the 10/06/2009 through 10/08/2009 dates of service."

Response Submitted by: Liberty Mutual Insurance Group. 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 6, 2009 through October 8, 2009	Inpatient Hospital Surgical Services	$3,434.16	$3,434.16

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 11, 2009
   - 45 — Z547 — THIS BILL WAS REVIEWED IN ACCORDANCE WITH OUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL (800) 937-6824. THIS REIMBURSEMENT MAY RELFECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH THE PPO NETWORK CONTRACT AND OUR ACCESS AGREEMENT WITH THEM. (Z547)
   - 42 —Z710 — THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - 42 — PA — FIRST HEALTH
   - 24 — P303 — THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)

   Explanation of benefits dated January 18, 2010
   - 45 — Z547 — THIS BILL WAS REVIEWED IN ACCORDANCE WITH OUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL (800) 937-6824. THIS REIMBURSEMENT MAY RELFECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH THE PPO NETWORK CONTRACT AND OUR ACCESS AGREEMENT WITH THEM. (Z547)
   - 42 —Z710 — THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - 42 — PA — FIRST HEALTH
   - 24 — P303 — THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)
   - B406 — DOCUMENTATION NOT SUBMITTED OR INSUFFICIENT TO ACCURATELY REVIEW THIS BILL. (B406)
   - X598 — CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE. (X598)

   Explanation of benefits dated February 22, 2010
   - 45 — Z547 — THIS BILL WAS REVIEWED IN ACCORDANCE WITH OUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL (800) 937-6824. THIS REIMBURSEMENT MAY RELFECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH THE PPO NETWORK CONTRACT AND OUR ACCESS AGREEMENT WITH THEM. (Z547)
   - 42 —Z710 — THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - 42 — PA — FIRST HEALTH
   - 24 — P303 — THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)
   - B406 — DOCUMENTATION NOT SUBMITTED OR INSUFFICIENT TO ACCURATELY REVIEW THIS BILL. (B406)
   - X598 — CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE. (X598)

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Which reimbursement calculation applies to the services in dispute?
3. Did the Requestor bill for implantables according to Texas Administrative Code §134.404
4. What is the maximum allowable reimbursement for the services in dispute?
5. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The insurance carrier reduced disputed services with reason code "45 — Z547 — THIS BILL WAS REVIEWED IN ACCORDANCE WITH OUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL (800) 937-6824. THIS REIMBURSEMENT MAY RELFECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH THE PPO NETWORK CONTRACT AND OUR ACCESS AGREEMENT WITH THEM" and 24 — P303 — THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303). Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on January 11, 2011 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

3. Per the respondent's position statement "Doctors Hospital at Renaissance submitted a blanket statement of certification with the implant invoices, however each invoice was not individually per TDI Rule 134.404(g)(1). This rule is for providers asking for separate reimbursement for implants. The provider must certify each invoice with the statement, 'I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge.' If the invoices do not contain this statement, then they do not get separate reimbursement. This verification statement of Rule 134.404(g)(1) was sent via email from one of the TDI medical dispute team." Texas Administrative Code §134.404(g)(1) states " A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge." Per the submitted documentation the provider submitted with the original bill a certification statement that meets the requirements of Texas Administrative Code §134.404(g)(1). Contrary to the respondent's position statement, 134.404(g)(1) does not require each implantable invoice to contain the certification statement. The Division finds that the requestor billed for implantables correctly, hence reimbursement for the implantables will be calculated per Texas Administrative code §134.404(g).

4. §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

   Review of the documentation found supports that the following items were certified as required by (g):

Itemized	Itemized	Cost Invoice	# Units & Cost	Cost Invoice	***Per item*** Add-on

Statement Rev Code or Charge Code	Statement Description	Description	Per Unit	Amount	(cost +10% or $1,000 whichever is less).
278	OR FLOSEAL HEMOSTATIC MATRIX 5ML	FLOSEAL HEMOSTATIC MATRIX	1 at $1,079.40 EACH	$1,079.40	$1,187.34
278	OR TISSEEL 2ML VH-KIT FIBRIN SEALANT	TISSEEL KIT 4 ML US	1 at $220.30 EACH	$220.30	$242.33
278	ORTHO BONE GRAFT CRUSHED CANCELLO C1713	30CC CRUSHED CANCELLOUS	1 at $365.00 EACH	$365.00	$401.50
278	BONE PUTTY VIAGRAF 5CC PER 0.5CC (C); C9359	BONE PUTTY VIA5CC PUTTY	9 at $649.44 EACH (BILLED 10 UNITS INVOICE SUPPORTS 9 UNITS)	$5,844.96	$6,429.46
278	CAGE ALIF CAP (RED MED)	12MM X 12 X 14 PEEK CAGE	1 at $11,000.00 EACH	$11,000.00	$12,000.00(exceeds the $1000 cap per billed item add-on)

$18,509.66	$20,260.63
Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

5. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

   - Documentation found supports that the DRG assigned to the services in dispute is DRG 460, and that the services were provided at Doctors Hospital at Renaissance. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $30,821.71. This amount multiplied by 108% results in an allowable of $33,287.45.
   - The total net invoice amount (exclusive of rebates and discounts) is $18,509.66. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,750.97. The total recommended reimbursement amount for the implantable items is $20,260.63.

   Therefore, the total allowable reimbursement for the services in dispute is $33,287.45 plus $20,260.63, which equals $53,545.08. The respondent issued payment in the amount of $37,363.26. Based upon the documentation submitted and the requestors *Table of Disputed Services* additional reimbursement in the amount of $3,434.16 is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration

of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does support the additional reimbursement amount sought by the requestor. As a result, the amount ordered is $3,434.16.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,434.16 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		May 29, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.